

UTAH DEPARTMENT OF HUMAN SERVICES
OFFICE OF RECOVERY SERVICES / CHILD SUPPORT SERVICES

PATERNITY QUESTIONNAIRE

SECTION I														
1. Mother's First Name	Mother's Middle Name	Mother's Last Name												
2. Alleged Father's First Name	Alleged Father's Middle Name	Alleged Father's Last Name												
3. Child's First Name	Child's Middle Name	Child's Last Name												
4. Child's Date Of Birth (mm/dd/yyyy)	5. Child's Gender (check one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE													
6. Where was the child conceived? (In which city and state did you get pregnant?)	City of Conception	State of Conception												
7. Child's City of Birth	Child's County of Birth	Child's State or Country of Birth												
8. Name of the hospital where this child was born														
9. Was the mother married to the father or to any other man during the time period beginning 300 days before this child was born? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PROVIDE THE FOLLOWING INFORMATION FOR EACH HUSBAND DURING THIS TIME PERIOD														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="padding: 5px;">Full Name Of Husband</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Date of Marriage</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Has the marriage ended? <input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td style="width: 25%; padding: 5px;">IF YES:</td> <td style="width: 50%; padding: 5px;">How did marriage end? (Divorce or Annulment)</td> <td style="width: 25%; padding: 5px;">Date Marriage Ended (mm/dd/yyyy)</td> </tr> </table>			Full Name Of Husband			Date of Marriage			Has the marriage ended? <input type="checkbox"/> No <input type="checkbox"/> Yes			IF YES:	How did marriage end? (Divorce or Annulment)	Date Marriage Ended (mm/dd/yyyy)
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Has the marriage ended? <input type="checkbox"/> No <input type="checkbox"/> Yes														
IF YES:	How did marriage end? (Divorce or Annulment)	Date Marriage Ended (mm/dd/yyyy)												
10. Has there been previous court action or other action regarding the paternity of your child? <input type="checkbox"/> No <input type="checkbox"/> Yes														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">IF YES:</td> <td style="width: 35%; padding: 5px;">Date (mm/dd/yyyy)</td> <td style="width: 50%; padding: 5px;">City, County and State of Action</td> </tr> <tr> <td></td> <td style="padding: 5px;">Civil Number of Action</td> <td style="padding: 5px;">Attorney Name/Phone Number</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Results of previous action:</td> </tr> </table>			IF YES:	Date (mm/dd/yyyy)	City, County and State of Action		Civil Number of Action	Attorney Name/Phone Number	Results of previous action:					
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11. Is the father listed above as the father on this child's birth certificate? <input type="checkbox"/> No <input type="checkbox"/> Yes														
12. Have you, at any time, named someone else as the father of this child? <input type="checkbox"/> No <input type="checkbox"/> Yes														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">IF YES:</td> <td colspan="2" style="padding: 5px;">Name(s) of other man/men named as the father of this child.</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Were genetic tests done? <input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td style="padding: 5px;">IF YES:</td> <td style="padding: 5px;">Date of Genetic Tests</td> <td style="padding: 5px;">Location of Genetic Tests</td> </tr> </table>			IF YES:	Name(s) of other man/men named as the father of this child.		Were genetic tests done? <input type="checkbox"/> No <input type="checkbox"/> Yes			IF YES:	Date of Genetic Tests	Location of Genetic Tests			
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Were genetic tests done? <input type="checkbox"/> No <input type="checkbox"/> Yes														
IF YES:	Date of Genetic Tests	Location of Genetic Tests												
13. During the months when this child could have been conceived (ten, nine, and eight months before the child's birth if the pregnancy was full term), did you have sexual intercourse with any man other than the father listed on this form? <input type="checkbox"/> No <input type="checkbox"/> Yes														
IF YES: Complete Section II IF NO: Skip to Section III														

ORS USE: TEAM **OR** **CASE:** _____

